HIT-HIE Update
November 16, 2009

As the absence of these Updates in recent weeks betrays, it has been a busy time for Health Information Technology (HIT) and Health Information Exchange (HIE) here in Vermont and across the country. There's a lot of information covered below, including updates on:

1 - HIT-HIE Stakeholder Meetings Schedule
2 - HIT & Higher Education Report: Complete!
3 - Status of the ONC Sec. 3013 and 3012 Cooperative Agreements: Submitted!
4 - Process moving forward for the VT HIT Plan: How you can be involved
5 - State Medicaid HIT Plan
6 - Provider Incentive Payments
7 - Meaningful Use
8 - Other national news and information

1. First, our **next HIT-HIE Stakeholder Meeting is Monday, December 14, 2:30-4:00 p.m**. at OVHA in Williston. (The schedule of meetings for the next year is here, along with a call-in number: http://hcr.vermont.gov/sites/hcr/files/_General_Stakeholders_Meeting_Schedule-_2010.pdf) Also, going forward, we will be integrating the scope of the HIT & Higher Education work group and the Regional Extension Center Advisory Board into the general Stakeholders' meeting as standing Agenda items related to work force, provider training, and support.

From time to time, we may need to establish additional work groups or sub-committees, but our hope is to respect everyone's time and try to keep meetings and their subject overlap to a minimum. At the same time, getting Stakeholder input is critically important going forward. It is not an exaggeration to say that one of the crucial elements to Vermont's status as a "leading HIT-HIE implementation state" (more on that below), is the work HIT-HIE Stakeholders have done since 2005 to help form a common vision for Vermont's HIT and HIE initiatives.

2. Attached, you will find the **HIT & Higher Education work group's Report**, just submitted to the legislature as required by Section 12 of Act 61. The work group did a fabulous job creating inventories of the types of positions required to meet HIT work force needs and the resources here in Vermont for training and education of that work force. I appreciate the hard work and time work group members put into our discussions and sub-committee work. Special thanks to Melissa Hersh from Champlain College, Sandy Bechtel from MBA Resources, Paul Forlenza from VITL, and Gerry Ghazi from Vermont HITEC for their essential contributions.

3. Both the **Section 3013 Cooperative Agreement for funding state HIE expansion** proposal and the **Section 3012 Cooperative Agreement for the Regional HIT Extension Center** (RHITEC) proposal have been submitted. The Section 3013 funding totals just over $5 million over four years. It is a non-competitive application, with funding allocated to states by formula. The funds will come to the State, although the majority will then be sub-granted to VITL to support the planning and then implementation of expansion of the HIE infrastructure. The Section 3012 RHITEC application, submitted by VITL, is competitive and would total $11.3 million if awarded. The Regional Extension Centers are designed to provide direct support to providers selecting, preparing for, and implementing EHR systems. (A helpful summary of VITL's application is attached.)

As you may recall, both of these sources of funding will help Vermont leverage the state Health IT Fund, enabling us to grow the HIT-HIE infrastructure and support EHR adoption more aggressively than would have been possible prior to the American Recovery & Reinvestment Act

(ARRA). That being said, the goal of statewide EHR adoption and ubiquitous exchange of health information is substantial, and we will need to leverage still more federal funding, if possible, to support that goal. Through discussions with federal officials regionally and in Washington, the opportunities for obtaining additional federal matching funds to support the HIE infrastructure look promising but remain very much in the "to be determined" mode. Vermont, like every state, is eligible for 90/10 match funding to support the work required to administer and oversee the Medicaid provider incentive payments, but we hope to also qualify for 90/10 funding (with the 10% coming from the HIT Fund) to support building out the HIE infrastructure beyond hospitals and physicians to all providers in the state. (An updated summary of the federal resources we're seeking to maximize and a visual representation of their potential uses is attached.)

4. Close observers of the process will recall that states had to submit their current state HIT Plans with the Section 3013 proposal. That version is posted here: http://hcr.vermont.gov/sites/hcr/files/IT_Strategic_Implementation_Plan_10-11-09_1.pdf. Between now and next April, we will be further refining the ***Vermont Health Information Technology Plan*** (VHITP), particularly with a focus on completing the operational / implementation plan, and we will be looking for input on that updating process through the Stakeholder Meetings.

Blueprint Director Dr. Craig Jones, VITL President/CEO Dr. David Cochran, and I have been meeting with providers and hospital staff around the state in each Hospital Service Area, to discuss the expansion of HIT-HIE capacity and Blueprint "readiness expansion." We will also be making a presentation at the December 16 Health Care Reform Commission meeting on this topic, and a comprehensive communication strategy to reach both additional providers and consumers is in development for roll-out over the winter.

The short summary of our approach is that we have strategically linked expansion of the Blueprint and HIT, since the initiatives are so integrally linked, and will be structuring HIT-HIE expansion to be fully coordinated and integrated with what hospitals, physicians, and other providers will need to support Blueprint expansion. Over the coming months, that will be formally articulated in the VHITP operations / implementation section; it is already described in the strategic plan section.

5. A closely related topic is the **State Medicaid HIT Plan** (SMHP), which states are required to complete to qualify for the 90/10 funding from CMS mentioned above. The SMHP will form "a chapter" – more likely an extensive series of chapters – of the VHITP, but the SMHP subsection does not have the same April 1 deadline as the rest of the VHITP. Agency of Human Services staff and I are completing what CMS calls an HIT P-APD (Planning – Advance Planning Document) that will be submitted shortly. Once approved, that will enable us to begin to draw down planning dollars from CMS to support both writing the SMHP and preparing for administering the Medicaid provider incentive payments.

6. Speaking of those **provider incentive payments**… Dr. Cochran has wryly observed that we are all operating under "temporal challenges" when it comes to the federal HIT funding. Nothing is sequenced in the order an engineer or CFO would like, and while we know much about the overall goals and direction, we continue to know a lot less than we would like to about the specifics of the Medicare and Medicaid provider incentive payments. But we're getting closer.

ONC, the Office of the National Coordinator for HIT, is in the process of making recommendations to CMS for the definitions of Meaningful Use and Certified Technology. Both of those definitions will be of critical importance to the **Interim Final Rule** expected from CMS ~ December 31, 2009. In that Interim Final Rule, we will learn "the rules of the road" for the incentive payments, including information on the apportionment of Medicare and Medicaid funding for hospitals. We will also learn CMS' definition of Meaningful Use and what kinds of

technology will qualify for HHS Certification. Between now and then, anything that anyone says that sounds definitive is truly speculation.

One other point to re-emphasize about the provider incentive payments: these come from Sections 4101 and 4201 of ARRA, and they are focused exclusively on a narrow list of provider types (physicians, nurse practitioners, nurse mid-wives, physician assistants, and dentists) who qualify based on the criteria we'll learn more about in the Interim Final Rule. However, the language in the HITECH Act section of ARRA that codified ONC and authorized its $2 billion in current appropriations (and authorizes further appropriations through 2013) defined providers *much more broadly.* Returning to the theme in # 3 above, we are still very much focused on seeking funding support for all of the other Medicaid providers (home health, long term care, mental health and substance abuse, etc.). You will see that reflected in the Vision section of the VHITP, and we will be pursuing that through the SMHP process as well.

7. Meaningful Use is a phrase that's continuing to get quite a lot of attention. I have attached a letter sent last Friday to the Acting Administrator of CMS, to Dr. Blumenthal at ONC, and to Peter Orszag, Director of the Office of Management and Budget (OMB) from the *Connecting for Health* collaborative led by the Markle Foundation, asking the feds to consider four criteria for the success of the Meaning Use rule:

1. Are there clear and achievable health and efficiency goals?
2. Do the requirements motivate information use to improve health and cost-effectiveness of care?
3. Do the requirements foster patient engagement in reaching Meaningful Use goals?
4. Do the requirements focus on information use and allow for ongoing innovation across a wide array of participants, rather than prescribing specific technology features?

Markle and *Connecting for Health* have received substantial attention from the documents and recommendations that they have presented on Meaningful Use this year, as well as for their Common Framework for Networked Health Information. You can read lots more about that work here: http://www.connectingforhealth.org/ I was pleased to be asked to join the *Connecting for Health* Steering Group earlier this fall to represent Vermont's perspective on these issues.

8. In closing, I wanted to note the attached Oct/Nov edition of The Commonwealth Fund *States in Action* newsletter, which provides some great detail on work being done at the state level in Arizona, New York, and Delaware. We focus a lot on the advances we've made here in Vermont, and while we're certainly a leader, other states are doing a lot of interesting, important work that we can learn from. I am nonetheless happy to note that the newsletter mentions "Minnesota, Wisconsin, and Vermont are among the states involved in cutting-edge HIT initiatives to support evidence-based medicine and improved patient care through transparent reporting of health outcomes and costs." The newsletter also features an interview with Dr. Blumenthal, and further below, I have appended an email the ONC chief sent out last Thursday on the importance of health information exchange in achieving HIT and health reform goals.

Finally, I wanted to note an article from "way back" in August that appeared in WIRED magazine and is archived here: http://www.wired.com/print/gadgets/miscellaneous/magazine/17-09/ff_goodenough It is titled "The Good Enough Revolution: When Cheap and Simple Is Just Fine" and offers some instructive ideas about why the fanciest technology with the most bells and whistles is not necessarily the most effective at driving change. Let's hope that CMS, ONC, and OMB recognize this and don't make the technology burden of certified technology for Meaningful Use too high. After all, the point of this work is not the computers, it is what we can use them to do, to improve patient care, safety, and quality of outcomes.

Happy hunting season and Happy Thanksgiving!

- Hunt

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8. *Continued from above*: Dr. Bluementhal's email from last Thursday

The HITECH Foundation for Information Exchange

November 12, 2009

A Message from Dr. David Blumenthal, National Coordinator for Health Information Technology

As the many activities mandated by the HITECH Act move forward, I want to take a moment to share my vision of the overarching goal and some of its implications. Our goal, above all else, is to make care better for patients, and to make it patient-centered. Information policy and health IT policy should serve that goal.

A key premise: information should follow the patient, and artificial obstacles – technical, business related, bureaucratic – should not get in the way. As a doctor, I have many times wanted access to data that I knew were buried in the computers or paper records of another health system across town. Neither my care nor my patients were well served in those instances. That is what we must get beyond. That is the goal we will pursue, and it will inform all our policy choices now and going forward. This means that information exchange must cross institutional and business boundaries. Because that is what patients need. Exchange within business groups will not be sufficient – the goal is to have information flow seamlessly and effortlessly to every nook and cranny of our health system, when and where it is needed, just like the blood within our arteries and veins meets our bodies' vital needs.

If we are to reap the benefit of information exchange, Americans must also be assured that the most advanced technology and proven business practices will be employed to secure the privacy and security of their personal health information, both within and across electronic systems, and that persons and organizations who hold personal health data are trustworthy custodians of the information. We must have comprehensive, clear, and sustainable policies that strengthen existing protections, fill gaps as they emerge, fortify new opportunities for patients' access to and control of their information, and align with evolving technologies. I will devote a separate letter to this critical issue and the many activities mandated by the HITECH Act that we are developing.

On the question of exchange, however, the HITECH Act is pretty specific about eliminating inappropriate barriers.

It squarely tackles the commercial barriers. The HITECH Act calls for the "*development of a nationwide health information technology infrastructure that allows for the electronic use and exchange of information and that…promotes a more effective marketplace, greater competition...[and] increased consumer choice*" among other goals. (Section 3001(b)) This means we cannot support arrangements that restrict the secure, private exchange of information required for patient care across provider or network boundaries. Some of these arrangements may improve care for those inside their walls. But ultimately, they have the potential to carve the nation up into disconnected silos of information, and thus, to undermine the vision of a secure, interoperable, nationwide health information infrastructure, which the law requires us to establish. Consumers, patients and their caretakers should never feel locked into a single health system or exchange arrangement because it does not permit or encourage the sharing of information.

It tackles the economic barriers. The HITECH Act incentives for providers and hospitals are powerful tools. While the official definition of "Meaningful Use" won't be finalized until next year, the HITECH Act specifically highlights "information exchange" as one requirement for the incentives.

It tackles the technical barriers. The HITECH Act focuses on "interoperability" or "interoperable products." In plain English, this means that our policies, programs, and incentives must aim for electronic health record (EHR) software and systems that can share information with different EHRs and networks so that information can follow patients wherever they go. And to build the pipelines to carry this information, HHS is directed to invest in the infrastructure to "support the nationwide electronic exchange and use of health information …including connecting health information exchanges…" (Section 3011) This means we will work with all our partners in the health and IT industries and with organizations that are committed to information sharing to develop the technologies and policies that can help us deliver information securely, privately, and accurately to whomever needs to see it on behalf of the patient's health. We must ensure interoperability for the future.

It provides building blocks for information exchange across jurisdictions. The grants for states and state-designated entities in Section 3013 – which will total $564 million – target information exchange across boundaries, *not only within each state but explicitly as part of a nationwide framework*. We will start announcing the awards this winter. These grantees' activities must support interoperability that lets patient data follow the patient across political and geographic boundaries. The grantees will be our partners in building the nationwide infrastructure mentioned previously.

In short, the HITECH Act not only authorizes but requires us to mobilize all our policies, programs, and incentives to give the American people the patient-centric care they deserve and expect.